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2200 INTRODUCTION

The Home and Community-Based Waiver (HCBW) Program recognizes that many individuals at risk of being placed in hospitals or nursing facilities can be cared for in their homes and communities, preserving their independence and ties to family and friends at a cost no higher than that of institutional care.

Nevada's Waiver for the Frail Elderly originated in 1987. The provision of waiver services is based on the identified needs of the waiver recipient. Every biennium the service needs and the funded slot needs of the waiver program are reviewed by the Division of Aging Services (DAS) and by the Division of Health Care Financing and Policy (DHCFP) (also known as Nevada Medicaid) and presented to the Nevada State Legislature for approval. Nevada is committed to the goal of providing the elderly with the opportunity to remain in a community setting in lieu of institutionalization. Nevada understands that people who are elderly are able to lead satisfying and productive lives when they are provided the needed services and supports to do so. The division is committed to the goals of self sufficiency and independence.

All Medicaid policies and requirements (such as prior authorization, etc.) are the same for Nevada Check Up, with the exception of the four areas where Medicaid and Nevada Check Up policies differ as documented in Chapter 3700.

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2201 AUTHORITY

Section 1915 (c) of the Social Security Act permits states the option to waive certain Medicaid statutory requirements in order to offer an array of home and community-based services to eligible individuals who may require such services in order to remain in their communities and avoid institutionalization. Nevada Medicaid's Home and Community-based Waiver for the Frail Elderly is an optional service program approved by the Centers for Medicare and Medicaid Services (CMS). This waiver is designed to provide eligible Medicaid waiver recipients access to both state plan services as well as certain extended Medicaid covered services unique this waiver. The goal is to allow recipients to live in their own homes, or community settings, when appropriate.

Nevada Medicaid has the flexibility to design this waiver and select the mix of waiver services that best meet the goals of the program. This flexibility is predicated on administrative and legislative support, as well as federal approval.

Statutes and Regulations:

Social Security Act: 1915 (c)
 Social Security Act: 1902 (w)
 Omnibus Budget Reconciliation Act of, 1987
 Balanced Budget of Act of 1997
 Health Insurance Portability and Accountability Act of 1996 (HIPAA)
 42 CFR Part 418
 42 CFR Part 431, Subpart E
 State Medicaid Manual, Section 4440
 Title 42 Code of Federal Regulations Part 441, Subparts G and H
 Nevada's Home and Community Based Waiver Agreement for the Frail Elderly
 Nevada Revised Statutes (NRS) Chapters 427A, 422, 232.357
 Nevada Administrative Code (NAC) Chapters 427A

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2202 DEFINITIONS

These are brief definitions, full detail is located in the section addressing the definition.

2202.1 ADMINISTRATIVE SERVICES

These services include the Division of Aging Services (DAS) applicant assessment activities and the plan of care development which occur prior to the approval of waiver eligibility by the Medicaid Central Office Waiver Unit and by the Nevada State Welfare Division (NSWD).

2202.2 ASSESSMENT

A written evaluation of each waiver applicant/recipient that includes the individual's abilities to perform activities of daily living, the individual's medical and social needs, the individual's support system and all other services received currently by the individual. This assessment is used to develop the applicant's/recipient's Plan of Care.

2202.3 CASE MANAGEMENT

This service assists person to access needed Home and Community-based waiver services, Medicaid State Plan services, as well as needed medical, social, educational, and all other services, regardless of the funding sources for the services to which access is gained.

2202.4 CHIP

The acronym for the "Community Home-based Initiative Program". The acronym includes two programs that are both operated by DAS. One program is for Medicaid waiver recipients. The other program is for State funded recipients. Both of these recipients receive Home and Community-based services in their own homes or places of residence as an alternative to institutional care.

2202.5 CHORE SERVICE

Extended homemaker service needed to maintain the recipient's living space as a clean, sanitary, and safe environment.

2202.6 COMPANION SERVICES

A non-medical care, supervision and socialization service provided to the functionally impaired adult in his/her home or place of residence, which provides temporary relief for the primary caregiver.

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2202.7 DAILY RECORD

The daily documentation completed by a provider indicating the time spent and the services provided. This record needs to be signed by the service provider and the recipient each visit. This not a medical record. This is a claim review record.

2202.8 DIVISION OF AGING SERVICES (DAS)

A State agency that is part of the Nevada's Department of Human Resources. DAS is contracted to operate the Home and Community-based Waiver for the Frail Elderly, provide case management and be the fiscal intermediary for waiver service providers.

2202.9 HOMEMAKER SERVICE

Services consisting of general household activities including cleaning, laundry, shopping, and meal preparation.

2202.10 INDIVIDUAL PROVIDERS

Individual providers are those who subcontract with DAS to provide Homemaker Services and/or Respite Services to Nevada Home and Community Based Waiver Services for the Frail Elderly.

The individual provider holds a current Nevada Medicaid provider number and receives all payments for waiver services from DAS. The individual provider must continue to meet the conditions of participation as stated in the Medicaid Service Manual Chapters 100 and 2200 as well as those stipulated in the provider contract for waiver services issued by DAS in order to continue to provide waiver services and submit claims for reimbursement.

2202.11 NURSING FACILITY LEVEL OF CARE

Identifies if an individual's total needs are such that they are routinely met on an inpatient basis in a nursing facility.

2202.12 NUTRITION THERAPY SERVICES

A range of nutrition intervention strategies provided by a registered dietitian to a nutritionally at risk individual.

2202.13 PERSONAL EMERGENCY RESPONSE SYSTEM (PERS)

An electronic device that enables certain individuals at high risk of institutionalization to secure help in an emergency.

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2202.14 PLAN OF CARE

The Plan of Care is a written document which identifies all of the applicant's or recipient's care and service needs. The plan of care is based on an assessment of the applicant's or recipient's health and welfare needs and is developed by the DAS case manager in conjunction with each applicant/recipient and/or his or her authorized representative.

2202.15 RESPITE SERVICE

Refers to those services provided to eligible recipients who are unable to care for themselves. These services are furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care.

2202.16 SERVICE PLAN

A service plan is the written description of personal care service needs developed by Nevada Medicaid staff or Medicaid's designee and the recipient or the recipient's personal representative. It outlines those specific tasks which the PCA is authorized to provide for the recipient.

2202.17 SLOT

The number of available opening for the waiver program that may be offered to eligible recipients during each State Fiscal Year (SFY). The number of slots available is determined by the amount legislative funding approved per SFY and through and agreement with CMS to fund this number of slots.

Open slots refer to the number of recipients on the waiver on any one day.

Unduplicated slots are the total number of recipients who are on the waiver in a specific time period.

2202.18 SOCIAL MODEL ADULT DAY CARE

Day Care Service provided for four (4) or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting. Day care centers provide care and supervision, the monitoring of general health, social interaction and peer contact for the physically or mentally impaired or socially isolated adult in order that he or she can remain in the community.

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2202.19 STATEMENT OF UNDERSTANDING

The form that indicates that the applicant/recipient has been given the right to choose between the Home and Community-based Waiver for the Frail Elderly and placement in a nursing facility.

2202.20 WAITING LIST

The list of waiver applicants who have been pre-screened and deemed eligible for the waiver and are waiting for a funded waiver slot.

2202.21 WAIVER YEAR

For the Home and Community-Based Waiver for the Frail Elderly, the waiver year begins July 1 and ends on June 30.

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2203 POLICY

2203.1 ELIGIBILITY CRITERIA

Nevada Medicaid's Home and Community-Based Waiver for the Frail Elderly waives certain statutory requirements and offers waiver services to eligible recipients to assist them to remain in their own homes or community.

2203.1A COVERAGE AND LIMITATIONS

1. Services are offered to eligible recipients who, without the waiver services, would require institutional care provided in a hospital or nursing facility. Recipients on this waiver must meet and maintain Medicaid's eligibility requirements for the waiver.
2. The Home and Community-Based Waiver for the Frail Elderly is limited by legislative mandate to a specific number of recipients who can be served through the waiver per year (slots). When all waiver slots are full, the Division of Aging Services utilizes a waiting list to prioritize applicants who have been presumed to be eligible for the waiver.
3. The waiting list is prioritized as follows:
 - a. Applicants currently in an acute care or nursing facility;
 - b. Applicants who are 85 years or older;
 - c. Applicants who have recently been discharged from a hospital;
 - d. Applicants who have active cases with Elder Protective Services; and,
 - e. Applicants already on the waiting list for the waiver for the frail elderly.
4. Medicaid must provide assurance to CMS that the State's total expenditures for home and community-based waiver services and other state plan Medicaid services for all recipients under this waiver will not exceed, in any year of the waiver period, 100 percent of the amount that would be incurred by Medicaid for all these recipients if they had been in an institutional setting in the absence of the waiver. Medicaid must also document that there are safeguards in place to protect the health and welfare of recipients.
5. Waiver services may not be provided while a recipient is an inpatient of an institution.
6. Home and Community-based Waiver for the Frail Elderly Eligibility Criteria:
The applicant/recipient must meet and maintain all eligibility criteria to become eligible and to remain on the Home and Community-based Waiver for the Frail Elderly.

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- a. Eligibility for Medicaid's Home and Community-based Waiver for the Frail Elderly is determined by the DHCFP, the Division of Aging Services (DAS), and the Nevada State Welfare Division (NSWD). These three State agencies collaboratively determine eligibility for the Frail Elderly Waiver as follows:
 1. Waiver benefit plan eligibility is determined by DAS and authorized by Medicaid Central Office Waiver Unit by confirming the following criteria:
 - a. Applicants or recipients must be 65 years of age or older;
 - b. Each applicant/recipient must meet and maintain a level of care for admission into a nursing facility and would require imminent placement in a nursing facility (within 30 to 60 days) if Home and Community-based waiver services or other supports were not available. The DAS case manager assesses a level of care according to the guidelines specified in Medicaid's Form Release NMO 3496, the instructions for the Level of Care and Service Place Assessment (NMO 3496).
 - c. Each applicant/recipient must demonstrate a continued need for the home and community-based waiver services for the frail elderly to prevent placement in a nursing facility or hospital. Utilization of State Plan Services only does not support the qualifications to be covered by the waiver.
 - d. The applicant/recipient must have an adequate support system. This support system must be in place to ensure the physical, environmental, and basic care needs of the recipient are met in order to provide a safe environment during the hours when home and community-based services are not being provided.
 2. Applicants must be approved by Medicaid's Central Office Waiver Unit.
 3. The eligibility determination for Medicaid benefits under the waiver program is made by NSWD.
 - a. Recipients of the Waiver for the Frail Elderly must be Medicaid eligible for full Medicaid benefits for each month in which waiver services are provided.
 - b. Services for the Home and Community Based Waiver for the Frail Elderly shall not be provided and will not be reimbursed until the applicant is found eligible for benefit plan services and full Medicaid eligibility.

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c. Medicaid recipients in the Home and Community-Based Waiver for the Frail Elderly may have to pay for part of the cost of the waiver services. The amount they are required to pay is called patient liability. SSI recipients do not have any patient liability.

1. Patient liability is determined by the Eligibility Certification Specialist (ECS) in the local Welfare Division district office. The following are excluded when determining patient liability:

- a. A maintenance allowance to care for the recipient's needs (rent, utilities, food, etc.) in the amount of 200% of the SSI need standard.
- b. A maintenance allowance for the spouse/dependent child(ren) (the ECS determine if the family members qualify for the deduction and the allowable amount of the deduction).
- c. Payments made by the recipient for health insurance premiums, deductibles and co-insurance charges not paid by Medicaid or other insurance, except for Medicare.
- d. Payments made by the recipient for medical care, recognized under State law, but not covered by the Medicaid program or other insurance. Payments for care which is above the Medicaid program limits are not excluded when determining patient liability.

2. When a case is approved or patient liability changes, the recipient, DAS and Medicaid's fiscal intermediary are notified by the ECS of the patient liability amount and the effective date. Collection of patient liability is the responsibility of DAS.

Patient liability for new approvals is effective on the first day of the month of approval.

When a recipient's income changes, patient liability is adjusted beginning with the month of the change. ECS notifies DAS of this change.

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3. When a recipient is discharged from the waiver, patient liability is prorated according to the number of days the recipient received waiver services during the month. If patient liability is inadvertently collected before discontinuing waiver services, the remaining balance, as determined by the ECS, must be refunded to the patient.
4. The actual amount of the patient liability is either the amount determined by the ECS or the actual cost of waiver services during the month, whichever is less. This amount is deducted from the amount billed to Medicaid for waiver services whether or not it is collected from the recipient. If no waiver service are provided during a month (e.g., a new case where services aren't initiated until after Medicaid eligibility approval), there is no patient liability.
5. Failure to pay patient liability is grounds for termination of waiver services.

2203.1B PROVIDER RESPONSIBILITIES

1. Providers are responsible for confirming the recipient's Medicaid eligibility each month prior to rendering services.
2. DAS is responsible for collecting patient liability.

2203.1C RECIPIENT RESPONSIBILITIES

Applicants/recipients must meet and maintain all criteria to be eligible and to remain on the Home and Community Based Waiver for the Frail Elderly.

2203.1D MEDICAID EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT)

Recipients of this waiver are not eligible for EPSDT.

2203.2 WAIVER SERVICES

Nevada Medicaid determines which services will be offered under the Home and Community Based Waiver for the Frail Elderly. Providers and recipients must agree to comply with all program requirements for service provision.

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2203.2A COVERAGE AND LIMITATIONS

Under this waiver, the following services are covered if identified in the Plan of Care as necessary to avoid institutionalization.

1. Case Management
2. Homemaker Services
3. Chore Services
4. Respite Care Services
5. Personal Emergency Response System (PERS)
6. Social Adult Day Care Services
7. Adult Companion Services
8. Nutrition Therapy Services

2203.2B PROVIDER RESPONSIBILITIES

1. All Service Providers:
 - a. Must obtain and maintain a Home and Community-based Waiver for the Frail Elderly provider number (48).
 - b. Must obtain and maintain a service provider contract with DAS.
 - c. Payments will not be made for services provided by a recipient's spouse, a minor child's parent, a legal guardian, or a legally responsible adult.
 - d. All providers may only provide services that have been identified in the Plan of Care and that have a prior authorization.
 - e. Providers must verify the Medicaid eligibility status of each Home and Community-Based Waiver for Frail Elderly recipients each month.
 - f. Providers who supply services to a recipient in the recipient's home shall have a criminal history background check from local law enforcement to ensure the health and welfare of recipients and to make every effort possible to prevent recipient abuse.

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- g. Providers must be able to perform the duties of the job; demonstrate maturity of attitude toward work assignments; able to converse effectively on the telephone; to work under intermittent supervision; to deal with minor emergencies arising in connection with the assignment, reporting these to the proper supervisor; ability to understand, respect and maintain confidentiality in regards to the details of case circumstances.
 - h. Each provider must accurately complete and sign the daily record for each recipient served. Periodically, Medicaid Central Office staff may request this documentation to compare it to billings submitted. These records must be maintained by the provider for at least six (6) years after the date the claim is paid.
 - i. The provider shall complete required training within six (6) months of beginning employment.
 - j. Cooperate with DAS and/or State or Federal reviews or inspections.
 - k. Report any recipient incidents or problems to DAS on a timely basis.
2. Division of Aging Services (DAS):
- a. Maintains compliance with the Interlocal Agreement with the Division of Health Care Financing and Policy to operate the Home and Community-based Waiver for the Frail Elderly.
 - b. Must comply with Appendix B-2 (C), entitled "Provider Requirements Applicable to Each Service" in Home and Community Base Waiver for the Frail Elderly
3. Agency Providers:
- a. Agencies employing providers of service to the waiver program must arrange training in at least the following subjects:
 - 1. policies, procedures and expectations of the agency relevant to the provider, including recipient's and provider's rights and responsibilities;
 - 2. procedures for billing and payment;
 - 3. record keeping and reporting;
 - 4. information about the specific needs and goals of the recipients to be served;

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5. interpersonal and communication skills and appropriate attitudes for working effectively with recipients including: understanding care goals; respecting recipient rights and needs; respect for age, cultural and ethnic differences; recognizing family relationships; confidentiality; respecting personal property; ethics in dealing with the recipient, family and other providers; handling conflict and complaints; and other topics as relevant.

6. any other training as designated by DAS

b. Exemptions from Training

1. The agency or its vendor agency, may exempt a prospective service provider from those parts of the required training where the agency judges the person to possess adequate knowledge or experience, or where the provider's duties will not require the particular skills.

2. The exemption and its rationale must be provided in writing and a copy of the exemption must be placed in the recipient's case record.

c. Complete an American with Disabilities Act (ADA) Self Evaluation to assure compliance with the Act.

4. Individual providers for Homemaker and Respite Care Services will:

Understand the assigned tasks, the allotted time given for each task and record keeping responsibilities, and billing procedures for provided waiver services.

2203.2C RECIPIENT RESPONSIBILITIES

The recipient or the recipient's authorized representative will:

1. notify the provider(s) and the DAS case manager of any change in Medicaid eligibility.
2. notify the provider(s) and DAS case manager of current insurance information, including the name of the insurance coverage, such as Medicare.
3. notify the provider(s) and case manager of changes in medical status, service needs, address or location changes, and/or any change in status of authorized or legal representative.
4. treat all providers and their staff members appropriately.
5. sign the daily record(s)/provider visit form(s) to verify that services were provided.

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6. notify the provider or DAS case manager when scheduled visits cannot be kept or services are no longer required.
7. notify the provider agency or DAS of any missed appointments by the provider agency staff.
8. notify the provider agency or the DAS case manager of any unusual occurrences, complaints regarding delivery of services, specific staff or to request a change in caregiver or provider agency.
9. furnish the provider agency with a copy of his or her Advance Directive.
10. not request any provider to work more than the hours authorized in the Plan of Care.
11. not request a provider to work or clean for a non-recipient, family or household members.
12. not request a provider to perform services not included in the Plan of Care.
13. contact the case manager to request a change of provider agency.
14. complete, sign and submit all required forms on a timely basis.

2203.3 CASE MANAGEMENT

2203.3A COVERAGE AND LIMITATIONS

These services are provided by DAS and include:

1. evaluation and/or reevaluation of the level of care every twelve (12) months or more often as needed;
2. assessment and/or reassessment of the need for waiver services every twelve (12) months or more often as needed;
3. development and/or review, in conjunction with the recipient, of the Plan of Care every twelve (12) months or more often as needed;
4. communication of the Plan of Care to all affected providers;
5. conduct the Functional Assessment (FA) and Service Plan on behalf of those recipients who have identified attendant care needs pursuant to MSM Chapter 3500;

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6. if personal attendant care (PCA) services are medically necessary, the case manager is then responsible for implementation of services and continued authorization of services pursuant to MSM Chapter 3500.
7. coordination of multiple services and/or providers;
8. submission of a prior authorization form to Medicaid's Quality Improvement Organization (QIO-like vendor) for all waiver services except Case Management;
9. identification of resources and assisting recipients in locating and gaining access to services with which to meet the recipient's needs;
10. monitoring and documenting the quality of care through monthly contact;
11. determination of the cost effectiveness of each waiver service for each applicant/recipient;
12. preparing and reviewing necessary billing for Medicaid payments and authorizing payment for waiver services;
13. monitoring the overall provision of waiver services, in an effort to protect the safety and health of the recipient and to determine that the Plan of Care goals are being met;
14. making certain that the recipient retains freedom of choice in the provision of services;
15. notifying all affected providers of changes in the recipient's medical status, services needs, address, and location, or of changes of the status of legally responsible adults or authorized representative;
16. notifying all affected providers of any unusual occurrence or change in status of a waiver recipient;
17. notifying all affected providers of any recipient complaints regarding delivery of service or specific provider staff;
18. notifying all affected providers if a recipient requests a change in the provider staff or provider agency.

2203.3 B PROVIDER RESPONSIBILITIES

Division of Aging Services case managers must meet and maintain the minimum qualifications in the State of Nevada class specifications of Social Worker II, class code 12.361.

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2203.3C RECIPIENT RESPONSIBILITY

1. Participate in the initial waiver assessment and annual reassessment process, accurately representing your functional abilities needs, wants, resources and goals.
2. In conjunction with the waiver case manager, develop and/or review the Plan of Care.

2203.4 HOME MAKER SERVICES

2203.4A COVERAGE AND LIMITATIONS

1. Homemaker services are provided by individuals or agencies under contract with the Division of Aging Services.
2. Homemaker services are provided when the individual regularly responsible for these activities is temporarily absent or unable to manage the home.
3. Nevada Medicaid is not responsible for replacing goods which are or become damaged in the provision of service.
4. Homemaker services include:
 - a. general cleaning, including mopping floors, vacuuming, dusting, cleaning the stove, changing and making beds, washing dishes, defrosting and cleaning the refrigerator, keeping the bathroom and kitchen clean, and washing windows as high as the homemaker can reach while standing on the floor;
 - b. shopping for the recipient's food and needed supplies;
 - c. planning and preparing varied meals, fitting them into the cultural, nutritional and economic standards of the recipient, preparing tray meals when needed, and preparing special diets under medical supervision;
 - d. washing, ironing and mending the recipient's personal laundry. The recipient pays all laundromat and/or cleaning fees;
 - e. assisting the recipient and family members or caregivers in learning homemaker routine and skills, so the recipient may carry on normal living when the homemaker is not present.
5. Activities the homemaker shall not perform and for which Medicaid will not pay include the following:

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- a. transporting, as the driver, the recipient in a private car.
 - b. cooking and cleaning for the recipient's guests, other household members or for the purposes of entertaining.
 - c. repairing electrical equipment.
 - d. ironing sheets.
 - e. giving permanents, dyeing or cutting hair.
 - f. accompanying the recipient to social events.
 - g. washing walls.
 - h. moving heavy furniture, climbing on chairs or ladders.
 - i. purchasing alcoholic beverages that were not prescribed by the recipient's physician.
 - j. doing yard work such as weeding or mowing lawns, trimming trees, shoveling non-essential snow covered areas, and vehicle maintenance.
6. If the recipient is in a Medicaid or Medicare funded hospice program, the recipient is not eligible to receive this waiver service.

2203.4B PROVIDER RESPONSIBILITIES

1. All Providers

- a. All persons performing services to recipients from this category will have a criminal history background check through local law enforcement to ensure the safety and well-being of recipients.
- b. Persons performing homemaker tasks shall meet the standards established by the Division of Aging Services. Providers are required to arrange and receive training related to household care, including good nutrition, special diets, meal planning and preparation, shopping information, housekeeping techniques, and maintenance of a clean, safe and healthy environment.
- c. Spouses of recipients, a legally responsible adult or a legal guardian may not be paid for homemaker services.

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- d. Providers will inform recipients that Nevada Medicaid is not responsible for replacement of goods damaged in the provision of service.
- e. Sign the daily record form, reflecting accurately the service given and the time spent providing the service.

2. Service Provider Agencies

No additional responsibilities

3. Individual Providers

- a. The individual provider must understand the assigned tasks, the allotted time, record keeping responsibilities, and billing procedures for provided waiver services.
- b. Individual providers must document the time spent and services provided to the recipient on the daily record form. This record must be signed by the recipient and be available for the case manager's review.
- c. Reimbursement for Homemaker service requires that the billing be initialed by a DAS case manager prior to submitting a claim for payment.

2203.5 CHORE SERVICES

2203.5A COVERAGE AND LIMITATIONS

- 1. This service includes heavy household chores such as:
 - a. cleaning windows and walls.
 - b. shampooing carpets.
 - c. tacking down loose rugs and tiles.
 - d. moving heavy items of furniture in order to provide safe access.
 - e. minor home repairs
 - f. removing trash and debris from the yard.
- 2. Chore services are intermittent in nature and may be authorized as a need arises for the completion of a specific task which otherwise left undone poses a home safety issue. These services are provided only in cases where neither the recipient, nor anyone else in

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the household, is capable of performing or financially providing for them, and where no other relative, caretaker, landlord, community volunteer/agency or third party payer is capable of, or responsible for, their provision and without these services the recipient would be at risk of institutionalization. This is not a skilled, professional service.

3. In the case of rental property, the responsibility of the landlord pursuant to the lease agreement, must be examined and confirmed prior to any authorization of service. The legal responsibility of the landlord to maintain and ensure safety on the rental property shall supercede any waiver program covered services.

2203.5B. PROVIDER RESPONSIBILITIES

1. All persons performing services from this category will have a criminal history background check from local law enforcement to ensure that those with a previous history of abuse or other violent crimes are not placed in a recipient's home.
2. Persons performing heavy household chores and minor home repair services need to maintain the home in a clean, sanitary and safe environment.
3. All individuals performing these services must:
 - a. Must be able to read, write, and follow written or oral instructions.
 - b. Must have experience and/or training in performing heavy household activities and minor home repair.

2203.6 RESPITE CARE

2203.6A COVERAGE AND LIMITATIONS

1. Respite care is provided for relief of the primary caregiver.
2. Respite care may occur in the recipient's home or place of residence or in a Medicaid certified nursing facility.
3. Respite care is limited to two weeks per year per individual if respite care is provided in the recipient's place of residence. Respite care is provided for 30 days annually if respite services are provided in a nursing facility.
4. Claims for Federal Financial Participation (FFP) are allowed for room and board costs when these services are provided as part of respite care furnished in a Medicaid certified nursing facility.

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5. If the recipient is in a Medicaid or Medicare funded hospice program, the recipient is not eligible to receive this waiver service.

2203.6B PROVIDER RESPONSIBILITIES

1. All persons performing services to recipients from this category will have a criminal history background check from local law enforcement to ensure the safety and well-being of the recipients.
2. Respite providers must:
 - a. perform general assistance with ADLs and IADLs and provide supervision to functionally impaired consumers in their home, place of residence or in a Medicaid certified nursing facility;
 - b. have the ability to read and write and to follow written or oral instructions;
 - c. have had experience and/or training in providing for the personal care needs of people with functional impairments;
 - d. demonstrate the ability to perform the care tasks as prescribed;
 - e. be tolerant of the varied lifestyles of the people served;
 - f. identify emergency situations and act accordingly;
 - g. have the ability to communicate effectively and document services provided;
 - h. maintain confidentiality regarding details of case circumstances;
 - i. Arrange training in personal hygiene needs and techniques for assisting with Activities of Daily Living, such as bathing, grooming, skin care, transferring, ambulating, exercise, feeding, dressing and use of adaptive aids and equipment, homemaking and household care.
3. Individual Providers
 - a. The individual provider must understand the assigned tasks, the allotted time, record keeping responsibilities, and billing procedures for provided waiver services.

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b. individual providers must document the time spent and services provided to the recipient on the daily record form. This record must be signed by the recipient and be available for the case manager's review.

4. If Respite Services are provided in a nursing facility, that facility must be licensed by the Health Division and have a viable Medicaid contract.

2203.7 PERSONAL EMERGENCY RESPONSE SYSTEM (PERS)

2203.7A COVERAGE AND LIMITATIONS

1. PERS is an electronic device, which enables certain recipients at high risk of institutionalization to secure help in an emergency. The recipient may also wear a portable "help" button to allow for mobility. The system is connected to the recipient's phone and programmed to signal a response center once a "help" button is activated.
2. PERS services are limited to those recipients who live alone, or who are alone for significant parts of the day, have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.
3. The necessity for this type of emergency safety measure to prevent institutionalization will be identified in the assessment and included in the Plan of Care.

2203.7B PROVIDER RESPONSIBILITIES

1. The provider must provide equipment approved by the Federal Communications Commission and the equipment must meet the Underwriters Laboratories, Inc. (UL) standard for home health care signaling equipment. The UL listing mark on the equipment will be acceptable as evidence of the equipments' compliance with such standard.
2. The emergency response activator must be able to be activated by breath, by touch, or some other means and must be usable by persons who are visually or hearing impaired or physically disabled.
3. The emergency response communicator must be attached to the PERS recipient's telephone line and must be capable of operating without external power during a power failure at the recipient's home in accordance with UL requirements for home health care signaling equipment with stand-by capability.
4. The monitoring agency must be capable of simultaneously responding to multiple signals for help from recipients' PERS equipment. The monitoring agency's equipment must include a primary receiver, a stand-by receiver, a back-up receiver power supply, and a

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telephone line monitor. The primary receiver and back-up receiver must be independent and interchangeable. The clock printer must print out the time and date of the emergency signal, the PERS recipient's Medical Identification Code (PIC) and the emergency code that indicates whether the signal is active, passive, or a responder test. The telephone line monitor must give visual or audible signals when an incoming telephone line is disconnected for more than 10 seconds. The monitoring agency must maintain detailed technical and operations manuals that describe PERS elements, including PERS equipment installation, functioning, and testing; emergency response protocols; and record keeping and reporting procedures.

5. Providers must inform recipients of any liability the recipient may incur as a result of the recipient's disposal of provider property.

2203.7C RECIPIENT RESPONSIBILITIES

1. The recipient is responsible to utilize the leased PERS equipment with care and caution and to notify the PERS provider or the DAS case manager when the equipment is no longer working.
2. The recipient must return the equipment to the provider when the recipient no longer needs or utilizes the equipment, when the recipient terminates from the waiver program or when the recipient moves from the area.
3. The recipient must not throw away the PERS equipment. This is leased equipment and belongs to the PERS provider.

2203.8 SOCIAL ADULT DAY CARE SERVICES

2203.8A COVERAGE AND LIMITATIONS

1. Social adult day care is a service provided for four (4) or more hours per day on a regularly scheduled basis.
2. It is provided in an outpatient setting.
3. It encompasses social service needs to ensure the optimal functioning of the recipient.
4. Meals provided are furnished as part of a program of adult day health services but must not constitute a "full nutritional regime" (i.e., three meals per day).
 - a. It is provided in accordance with the goals in the recipient's Plan of Care and not merely diversional in nature.

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- b. Transportation costs for transportation between the consumer's residence and the social adult day care center is not provided as a component part of social adult day care reimbursement expense.

2203.8B PROVIDER RESPONSIBILITIES

Day Care Provider:

Meet and maintain specifications as a social day care center provider as outlined in NRS 449.

2203.9 ADULT COMPANION SERVICES

2203.9A COVERAGE AND LIMITATIONS

1. Provides non-medical care, supervision and socialization to the functionally impaired recipient in his or her home or place of residence, which would provide temporary relief for the primary caregiver.
2. Assist the recipient with such tasks as meal preparation and clean up, light housekeeping, shopping and transportation/escort as needed. These services are provided as an adjunct to the Adult Companion Services and must be incidental to the care and supervision of the recipient.
3. The provision of Adult Companion Services does not entail hands-on medical care.
4. This service is provided in accordance with a goal in the Plan of Care and is not purely diversionary in nature.
5. If the recipient is in a Medicaid or Medicare funded hospice program, the recipient is not eligible to receive this waiver service.

2203.9B PROVIDER RESPONSIBILITIES

1. Must be able to read and write to follow written or oral instructions.
2. Must have experience or training in the care of recipients with disabling conditions.

2203.10 NUTRITION THERAPY SERVICES

2203.10A COVERAGE AND LIMITATIONS

The nutritional services to be provided include an initial assessment to measure the nature and extent of nutrition related risk factors in order to plan appropriate interventions. These

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interventions include nutrition education and counseling. Nutrition services will be provided in the recipient's home with a total of three visits annually. The first visit will consist of the initial comprehensive nutrition assessment, with two follow-up visits to include education and/or counseling. At the current time, these services are being provided under Registered Dietician Services under the State Plan. Refer to Medicaid Services Manuals Chapter 600 and 1400 for service guidelines.

If the recipient is in a Medicaid or Medicare funded hospice program, the recipient is not eligible to receive this waiver service.

2203.10B PROVIDER RESPONSIBILITIES

The provider will obtain and maintain licensure or registration as a dietician.

2203.11 PROVIDER ENROLLMENT/TERMINATION

All providers must comply with all DHCFP provider enrollment requirements, provider responsibilities/qualifications, and DHCFP provider agreement limitations. Provider non-compliance with any or all of these stipulations may result in Nevada Medicaid's decision to exercise its right to terminate the provider's contract.

2203.11.A COVERAGE AND LIMITATIONS

All providers are to refer to the Medicaid Services Manual Chapter 100 for enrollment procedures.

2203.11B PROVIDER RESPONSIBILITY

1. All providers must maintain an active provider number and must meet all state and federal requirements as a Medicaid provider.
2. DAS must:

Have an interlocal agreement with the Division of Health Care Financing and Policy in order to provide services statewide for the frail elderly.
3. All Other Service Providers must:
 - a. Apply for and maintain a contract with DAS.
 - b. Apply and maintain any State required licenses.

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2203.12 INTAKE PROCEDURES

Nevada Medicaid has developed policies and procedures to ensure fair and adequate access to the Home and Community-Based Waiver for the Frail Elderly.

2203.12A COVERAGE AND LIMITATIONS

1. SLOT PROVISION

- a. The allocation of waiver slots is maintained at DAS's Central Office in Carson City with sub-lists located at the DAS local offices. As waiver slots become available, DAS determines how many slots may be allocated to each local office and notifies each office of the available funded slots.
- b. If a Home and Community-Based Waiver for the Frail Elderly recipient voluntarily terminates from the waiver (e.g., moves out of state, fails to cooperate or requests that his or her waiver services be terminated, etc.) then at a later date, wants to be considered for the waiver, that person's name will be placed on the waiting list based on the new referral date.
- c. If a Home and Community-Based Waiver for the Frail Elderly recipient involuntarily terminates from the waiver (e.g., has been placed in a nursing facility or hospital) but later wants to be reconsidered for the waiver, if the hospital or nursing facility discharge has occurred in the same waiver year, and, if that person still meets the eligibility criteria, that person's name will be placed back on the Waiver for the Frail Elderly.

2. TELEPHONE REFERRAL

- a. A referral or inquiry for the waiver may be made by a potential applicant or by another party on behalf of the potential applicant by contacting the local DAS office and speaking to the intake worker. The intake worker will discuss the waiver including the eligibility requirements of the waiver with the referring party or the applicant.
- b. If the potential applicant wants to apply for the waiver, the intake worker will inform him/her of the necessity to submit a Medicaid application to NSWD.
- c. If the intake worker determines during the referral process that the potential applicant does not appear to meet the waiver criteria of financial eligibility, level of care, or waiver service need, the applicant will be referred to other agencies for any needed services or assistance.

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- d. Even if the potential applicant does not appear eligible for the Home and community-Based Waiver for the Frail Elderly, he or she must be verbally informed of the right to continue the Medicaid application process through NSWDC. If the NSWDC determines the applicant to be ineligible for Medicaid, the applicant may have the right to a fair hearing through the NSWDC.

3. WAITING LIST/NO WAIVER SLOTS ARE AVAILABLE

- a. Once DAS has identified that the potential applicant appears eligible or if the applicant wishes to continue with the intake process or if the applicant has filed a Medicaid application through NSWDC, and there are no waiver slots available, then:

1. The applicant will be placed on the waiver waiting list with the date of the referral to DAS as the ranking date.

- a. Once an applicant is placed on the waiting list through DAS and the applicant has submitted a Medicaid application through NSWDC, DAS will email the names of those applicants waiting for final approval to the Medicaid Central Office Waiver Unit on a weekly basis.

If it has been determined no slot is expected to be available within the 90 day determination period DAS will notify Medicaid Central Office Waiver Unit to deny the application due to no slot available. The applicant will remain on the waiting list.

If an applicant has been pending for 30 days, a pending notice stating why a decision has not been made will be sent to the applicant by the Medicaid Central Office Waiver Unit. If an applicant has not been approved within 60 days, another pending notice will be sent to the applicant by the Medicaid Central Office Waiver Unit. If the applicant has not been approved after 90 days, the application will be denied and the Medicaid Central Office Waiver Unit will send out a Notice of Decision stating the reason for the denial.

- b. If DAS has identified that no Medicaid application has been made through NSWDC and that the applicant wants DAS to help to file this application; and there are no waiver slots available, the applicant will be placed on the waiver waiting list with the date of the referral to DAS as the ranking date. When a slot is available,

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DAS will assist with the Medicaid application process. There will be no official notices of decision as there is no official application.

4. A WAIVER SLOT IS AVAILABLE

Once a slot for the waiver is available, the applicant, who has been assigned a waiver slot, will be processed for the waiver.

a. The procedure used for processing an applicant will be as follows:

1. The DAS case manager will make certain that the Medicaid application, through NSWD, has been completed or updated and will assist in this process as needed.
3. The DAS case manager will schedule a face-to-face interview with the applicant to complete the assessment.
3. An Authorization for Release of Information form is needed for all waiver recipients and provides written consent for DAS to release information about the recipient to others.

The applicant and/or authorized representative must understand and agree that personal information may be shared with providers of services and others as specified on the form.

The DAS case manager will inform the applicant and/or authorized representative that, pursuant to NRS 232.357, the Divisions within the Nevada Department of Human Resources may share confidential information without a signed Authorization for Release of Information.

4. The applicant/recipient will be given the right to choose waiver services in lieu of placement in a nursing facility. If the applicant and/or legal representative prefers placement in a nursing facility, the case manager will assist the applicant in arranging for facility placement.
5. The applicant/recipient will be given the right to request a hearing if not given a choice between home and community based services and nursing facility placement.
6. When the applicant/recipient is approved for the waiver and Medicaid waiver eligibility has been determined, then:

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- a. A written Plan of Care is developed in conjunction with the recipient by the DAS case manager for each recipient under the waiver. The Plan of Care is based on the assessment of the recipient's health and welfare needs.
 - b. The recipient or the recipient's family or legal representative should participate in the development of the Plan of Care.
 - c. The Plan of Care is subject to the approval by the Medicaid Central Office staff.
 - d. Recipients will be given free choice of all qualified Medicaid providers of each Medicaid covered service included in his/her written Plan of Care. Current Plan of Care information as it relates to the services provided must be given to all service providers.
7. All forms must be complete with signature and dates where required.
8. DAS will forward all completed packet forms plus a 2734 requesting approval to the Medicaid Central Office Waiver Unit.
 - a. If the application is not approved by the Medicaid Central Office Waiver Unit, the following will occur:
 1. A NOD stating the reason(s) for the denial will be sent to the applicant by the Medicaid Central Office Waiver Unit via the Hearings and Policy Unit.
 2. A 2734 will be sent to DAS and NSWDC by the Medicaid Central Office Waiver Unit stating that the application has been denied and the reason(s) for that denial.
 - b. If the Medicaid Central Office Waiver unit approves the application, the following will occur:
 1. A 2734 will be sent by the Medicaid Central Office Waiver Unit to DAS and NSWDC stating the application has been approved.
 2. Once the Medicaid Central Office Waiver Unit and NSWDC have approved the application, waiver service can be initiated.

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9. If the applicant/recipient is denied by DAS for waiver services:

- a. the DAS case manager will send a Notice of Action (NOA) to the Central Office Medicaid Central Office Waiver Unit.
- b. the Medicaid Central Office Waiver Unit will send a NOD to the applicant via the Hearings and Policy Unit stating the reason(s) why the application was denied by DAS.
- c. The Medicaid Central Office Waiver Unit will send a 2734 to DAS and NSWDC stating that the application was denied and the reason(s) for the denial.

5. EFFECTIVE DATE FOR WAIVER SERVICES

The effective date for waiver services approval is the completion date of all the intake forms and the Medicaid eligibility determination date, whichever is later. If the applicant is in an institution, the effective date cannot be prior to the date of discharge from the institution.

6. WAIVER COST

Medicaid must assure CMS that the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures for the institutional level of care under the state plan that would have been made in that fiscal year, had the waiver not been granted.

2203.13 BILLING PROCEDURES

The State assures that claims for payment of waiver services are made only when an individual is Medicaid eligible and only when the service is included in the approved Plan of Care.

2203.13A COVERAGE AND LIMITATIONS

All Providers (48) for the waiver for the Frail Elderly must complete the CMS 1500 for payment of waiver services and then forward the completed form to the appropriate local DAS office. DAS will authorize payment and send the form to Medicaid's fiscal agent. Incomplete or inaccurate claims will be returned to DAS by Medicaid's fiscal agent. If the wrong form is submitted, it will also be returned to DAS by Medicaid's fiscal agent.

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2203.13B PROVIDER RESPONSIBILITIES

Refer to Section 2205.1 of this Medicaid Services Manual for detailed instructions for completing the DAS billing form or CMS billing form and for a list of covered procedure codes.

2203.14 ADVANCE DIRECTIVES

Section 1902(w) of the Social Security Act requires licensed provider agencies providing personal care services to give their clients information about their decision-making rights about health care, declarations (living wills) and durable powers of attorney for health care decisions. Refer to Medicaid Service Manual 100 for further information.

DAS will provide information on Advance Directives to each applicant/ recipient and/or the authorized/legal representative. The signed form is kept in each recipient's file at the local DAS office. Whether a recipient chooses to write his or her own Advance Directives or complete the Advance Directives form in full is the individual choice of each applicant/recipient and/or each applicant/recipient's authorized/legal representative.

2203.15 CASE MANAGER RECIPIENT CONTACTS

a. Monthly Contact

1. The DAS case manager must have a monthly contact with each waiver recipient or the recipient's authorized representative; this may be a phone contact. At a minimum, there must be a face-to-face visit with each recipient once every three months. More contacts may be made if the recipient has indicated a significant change in his or her health care status or is concerned about his or her health and/or safety.
2. During the monthly contact, the case manager determines if there are any issues with the service provision and/or the recipient's satisfaction with the provided services. The case manager also assesses the need for any change in services or providers, and determines whether the services are promoting the goal(s) stated in the Plan of Care.

b. Reassessment

The recipient's level of care, functional status and needs addressed by the Plan of Care must be reassessed annually or more often as needed. The first reassessment must be completed within 12 months of the waiver approval date. The recipient must also be reassessed when there is a significant change in his /her condition. The reassessment is to be conducted during a face-to-face visit.

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2203.16 MEDICAID'S ANNUAL REVIEW

The State will have in place a formal system in which an annual review will be conducted to assure the health and welfare of the recipients served on the waiver, the recipients' satisfaction with the waiver and to assure the cost effectiveness of these services.

2203.16A COVERAGE AND LIMITATIONS

The State will conduct an annual review, which is collaboratively conducted by DAS and Medicaid with Medicaid being the lead agency; and:

1. Provide CMS annually with information regarding the impact of the waiver on the type, amount, and cost of services provided under the waiver and under the State plan, and the health and welfare of the recipients served on the waiver.
2. assure financial accountability for funds expended for Home and Community-based services.
3. evaluate that all provider standards are continuously met, and that the plans of care are periodically reviewed to assure that the services furnished are consistent with the identified needs of the recipients.
4. evaluate the recipients' satisfaction with the waiver program.
5. further assure that all problems identified by this monitoring will be addressed by the provider in an appropriate and timely manner, consistent with the severity and nature of the deficiencies.

2203.16B PROVIDER RESPONSIBILITIES

DAS and its providers must cooperate with Medicaid's annual review process.

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2204 APPEALS AND HEARINGS

2204.1A SUSPENDED WAIVER SERVICES

1. If it is likely the recipient will be eligible again for waiver services within the next 60 days (for example, if a recipient is admitted to a hospital or nursing facility), a recipient's case may be suspended instead of closed.
2. If at the end of the 45 days the recipient has not been removed from suspended status, the case must be closed. DAS will send a Notice of Action (NOA) to the Medicaid Central Office Waiver Unit identifying the 60th day of suspension as the effective date of termination and the reason for the waiver termination.
3. The Medicaid Central Office Waiver Unit will then send a Notice of Decision (NOD), via the Medicaid Hearings and Policy Development Unit, to the recipient or the recipient's authorized or legal guardian advising him or her of the date of the waiver termination and the reason for the waiver closure/termination.

2204.1B RELEASE FROM SUSPENDED WAIVER SERVICES

If a recipient has been released from the hospital, nursing facility or ICF/MR before 60 days have elapsed, within five (5) working days of the recipient's discharge, the case manager must:

1. complete a new Level of Care assessment tool if there has been a significant change in the recipient's condition or if it appears the recipient may not meet a level of care.
2. complete a reassessment if there has been a significant change in the recipient's condition or status.
3. complete a new Plan of Care if there has been a change in services (medical, social or waiver). If a change in services is expected to resolve in less than 30 days, a new Plan of Care is not necessary. Documentation of the temporary change must be made in the case manager's notes. The date of resolution must also be documented in the case manager's notes.
4. contact the service provider(s) to reestablish services.

2204.1C DENIAL OF WAIVER APPLICATION

Basis of denial for waiver services:

1. The applicant is under the age of 65 years.

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2. The applicant does not meet the level of care criteria for nursing facility placement.
3. The applicant has withdrawn his or her request for waiver services.
4. The applicant fails to cooperate with DAS or home and community based service providers in establishing and/or implementing the Plan of Care, implementing waiver services or verifying eligibility for waiver services. (The recipient's or recipient's authorized or legal representative's signature is necessary for all required paperwork.)
5. The applicant's support system is not adequate to provide a safe environment during the time when home and community-based services are not being provided.
6. DAS has lost contact with the applicant.
7. The applicant fails to show a need for home and community based waiver services.
8. The applicant would not require nursing facility placement if home and community based services were not available.
9. The applicant has moved out of state.
10. Another agency or program will provide the services.
11. DAS has filled the number of positions (slots) allocated to the Home and Community Based Waiver Program for the Home and Community based waiver for the Frail Elderly. The applicant has been approved for the waiver waiting list and will be contacted when a slot is available.
12. The applicant is in an institution (e.g. hospital, nursing facility, correctional, ICF/MR) and discharge within 30 days is not anticipated.

When the application for waiver services is denied, the case manager will send a Notice of Action (NOA) to the Medicaid Central Office Waiver Unit. The Medicaid Central Office Waiver Unit will then send a Notice of Decision to the applicant or the applicant's authorized or legal representative, via the Medicaid Hearings and Policy Development Unit letting them know that waiver services have been denied and the reason for the denial.

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2204.1D TERMINATION OF WAIVER SERVICES

Reasons to terminate a recipient from the waiver or to terminate the recipient from the waiver waiting list:

1. The recipient has failed to pay his/her patient liability.
2. The recipient no longer meets the level of care criteria for nursing facility placement.
3. The recipient has requested termination of waiver services.
4. The recipient has failed to cooperate with DAS or home and community based waiver service providers in establishing and/or implementing the Plan of Care, implementing waiver services, or verifying eligibility for waiver services. (The recipient's or the authorized or legal representative's signature is necessary on all required paperwork).
5. The recipient's support system is not adequate to provide a safe environment during the time when home and community based services are not being provided.
6. The recipient fails to show a continued need for Home and Community-based waiver services.
7. The recipient no longer requires nursing facility placement if Home and Community-based services were not available.
8. The recipient has moved out of state.
9. The recipient has submitted fraudulent documentation on one or more of the provider time sheets and/or forms.
10. Another agency or program will provide the services.
11. The recipient has been, or is expected to be, institutionalized over 60 days (in a hospital, nursing facility, intermediate facility for persons with mental retardation).
12. DAS has lost contact with the recipient.

When a recipient is terminated from the waiver program, the DAS case manager will send the Medicaid Central Office Waiver Unit a NOA stating the date of termination and the reason(s) for the termination. The Medicaid Central Office Waiver Unit will then send a NOD via the Hearings and Policy Development Unit to the recipient or to the recipient's authorized or legal representative. The NOD must be mailed by the Division of Health Care Financing and Policy, Hearings and Policy Unit, at least thirteen (13) calendar days before the listed date of action on

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the form. Refer to Medicaid Services Manual, Chapter 3100, for specific instructions regarding notice and recipient hearings.

2204.1E REDUCTION OF WAIVER SERVICES

Reasons to reduce services are:

1. The recipient no longer needs the number of service hours which were previously provided.
2. The recipient no longer needs the service previously provided.
3. The recipient's support system is providing the service.
4. The recipient has failed to cooperate with the DAS case manager or home and community based service provider(s) in establishing and/or implementing the Plan of Care, implementing waiver services or verifying eligibility for waiver services. (the recipient's or the recipient's authorized representative's signature is necessary on all required paperwork.)
5. The recipient has requested the reduction of services.
6. The recipient's ability to perform activities of daily living has improved.
7. Another agency or program will provide the service.
8. Another service will be substituted for the existing service.
9. The cost of all waiver services exceeds 100% of the cost of nursing facility care.

When there is a reduction of waiver services, the DAS case manager will send a reduction of services form to the Medicaid Central Office Waiver Unit. The Medicaid Central Office Waiver Unit will then send a NOD through the Hearings and Policy Development Unit to the recipient or the recipient's authorized or legal representative. The form must be mailed by the Hearings and Policy Development Unit to the recipient at least 13 calendar days before the Date of Action on the form.

Refer to Medicaid Services Manual, Chapter 3100, for specific instructions regarding notice and recipient hearings.

2204.2 REAUTHORIZATION WITHIN 90 DAYS OF WAIVER TERMINATION

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2204.2A COVERAGE AND LIMITATIONS

1. If waiver services have been terminated and the applicant/recipient is eligible for readmission to the waiver as defined in 2203.13 A. 1. b and c and is requesting reapproval within 90 days of closure, the DAS case manager must complete and send to the Medicaid Central Office Waiver Unit the following:
 - a. A new Level of Care form if there has been a significant change in the recipient's condition.
 - b. Reassessment.
 - c. A new Statement of Understanding if there has been a change in the authorized/legal representative.
 - d. A new Plan of Care if services have changed.
 - e. A Home and Community Based Waiver Eligibility Status Form (Form # 2734) requesting Medicaid Central Office Waiver Unit approval with the date of approval indicated.

All forms must be complete with signatures and dates.
2. If a recipient is terminated from the waiver for more than 90 days, and if slots are available as determined by DAS, and if the recipient/applicant is eligible for readmission to the waiver as defined in Section 2203.13A.4, a new complete waiver packet for a new authorization must be completed by the DAS case manager and forwarded to the Medicaid Central Office Waiver Unit.

2204.2B SERVICE PROVIDERS RESPONSIBILITIES

There are no provider responsibilities associated with this section.

2204.2C RECIPIENT RESPONSIBILITIES

Recipients must cooperate fully with the reauthorization process to assure approval of his/her request for readmission to the waiver.

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2205 REFERENCES AND CROSS REFERENCES

2205.1 PROVIDER SPECIFIC INFORMATION

Specific information about each provider type can be found in the following chapters:

Chapter 100 Eligibility, Coverage and Limitations
Chapter 500 Nursing Facility Services
Chapter 3100 Hearings
Chapter 3200 Hospice
Chapter 3300 Surveillance and Utilization Review
Chapter 3500 Personal Care Aide Program
Chapter 3600 Managed Care Organization
Chapter 3700 Nevada Checkup
Nevada State Welfare Division MAABD Manual Section 360

2205.2 CONTACTS

a. Division of Aging Services Offices:

1. Las Vegas (serves Clark, Nye, Lincoln, and Esmeralda Counties)
3100 W Sahara Avenue
Ste # 103
Las Vegas NV 89102
702-486-3545
2. Reno (serves Churchill, Pershing, and Washoe counties and parts of Lyon County)
445 Apple Street
Ste # 104
Reno NV 89502
775-688-2964
3. Carson City (serves Carson City and Douglas, Mineral, and Storey Counties and parts of Lyon County)
3416 Goni Road
Ste #D132
Carson City NV 89710
775-687-4210

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4. Elko (serves Elko, Eureka, Humboldt, Lander, and White Pine Counties)
850 Elm Street
Elko, NV 89801
775-738-1966

2205.3 FIRST HEALTH SERVICES CORPORATION

PROVIDER RELATIONS UNITS

Provider Relations Department
First Health Services Corporation
PO Box 30026
Reno, Nevada 89520-3026
Toll Free within Nevada (877) NEV-FHSC (638-3472)
Email: nevadamedicaid@fhsc.com

PRIOR AUTHORIZATION DEPARTMENTS

First Health Services Corporation
Nevada Medicaid and Nevada Check Up
HCM
4300 Cox Road
Glen Allen, VA 23060
(800) 525-2395

PHARMACY POINT-OF-SALE DEPARTMENT

First Health Services Corporation
Nevada Medicaid Paper Claims Processing Unit
PO Box C-85042
Richmond, VA 23261-5042
(800) 884-3238